Cigna Healthcare, Global Health Benefits℠ HIPAA Request for an Accounting of Disclosures of Individually Identifiable Health Information

This form will allow me, as a Cigna Healthcare, Global Health Benefits customer/participant, to request an accounting of disclosures of my Individually Identifiable Health Information for the purposes other than treatment, payment and/or health care operations and other exceptions under the Privacy Rule.

Effective as of April 14, 2003, Cigna Healthcare, Global Health Benefits will provide an accounting of a customer/participant's disclosures of individually identifiable health information for up to six (6) years prior to the date of the customer/participant's request.

When a request for an accounting of disclosures of individually identifiable health information is received, it will be provided within sixty (60) days. If necessary, this time frame may be extended for thirty (30) days. The customer/participant requesting the accounting will be informed in writing, within sixty (60) days of the original request, of the reason(s) for the extension and the date by which action will be taken upon the request.

A customer/participant may receive an accounting of disclosures once during any twelve (12) month period at no charge. If a customer/participant requests more than one accounting within the same twelve (12) month period, Cigna Healthcare, Global Health Benefits may charge such customer/participant a cost-based fee.

Identification of customer/participant requesting an Accounting of Disclosures: The following information is needed for verification:

Name of Customer/Participant Requesting an Accounting of Disclosures Date of Birth

Customer ID Number

Subscriber's Name (if different from Customer)

Subscriber's Relationship to Customer

Subscriber's Employer Name

Subscriber's Customer ID Number

Telephone Number

Email Address

Please return the signed and completed form to the following address:

Privacy Office
Cigna Healthcare, Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

I understand that any form returned to Cigna Healthcare, Global Health Benefits incomplete will be returned to me for completion and my request for an accounting of disclosures will not be implemented until all the information is received complete and processed.

I also understand that if either I, as a customer/participant or group subscriber changes health care benefits coverage or employers that I will need to resubmit this request.

Please Complete Next Page

I have read and understand the above information:

Date: _____ Signature of Authorizing Customer/Participant: _____

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of _ years of age or is unable to give consent, because: _____

Signature of Parent/Guardian/POA: _____ Relationship: _____

Signature of Personal Representative: _____ Relationship: _____

HIPAA AA02

Clear Form

853885a 06/2025